

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3082

CERTIFICATE OF DEATH

Reg. Dist. No. 03059

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>From 2/24/59</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>LAKE</u> Last <u>AARON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Aaron</u>		14. MOTHER'S MAIDEN NAME <u>VICTORIA WILLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOsCLEROTIC heart disease</u> DUE TO (b) <u>Far advanced Arteriosclerosis</u> DUE TO (c) <u>several yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 24, 1959</u> to <u>MARCH 26, 1959</u> , that I last saw the deceased alive on <u>3-26</u> 19 <u>59</u> , and that death occurred at <u>8:00 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D. ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSPITAL</u> DATE SIGNED <u>3/26/59</u> PHYSICIAN'S NAME (Type) <u>SIMON VIRKUTIS</u> <u>Cambridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anneth R. Thomas</u> ADDRESS <u>Cambridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

11-10-53

CRIMINAL DIVISION

308-2



16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3083

CERTIFICATE OF DEATH

03060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> <u>07X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>07X-2</u>			
3. NAME OF DECEASED (Type or print) <u>David - George W. Alexander</u> First Middle Last				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-84</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James D Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Anna McKinney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT Address <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardial Degen-</u> <u>422.2</u> DUE TO <u>eration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>eration</u> DUE TO (c) <u>eration</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 26</u> , 1955, to <u>Mar 5</u> , 1959, that I last saw the deceased alive on <u>Mar 4</u> , 1959, and that death occurred at <u>7:22 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thomas J Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> <u>3-5-59</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant, North East Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3068

CERTIFICATE OF DEATH

03061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Maryland Hosp.</u>		d. STREET ADDRESS <u>312 Oakley St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Spedden</u> Last <u>Batchler</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1887</u>
9. AGE (In years lost birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Oliver Spedden</u>	
14. MOTHER'S MAIDEN NAME <u>Carline Spedden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Mrs Herbert Hearn Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 days</u> <u>12 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>3</u> Day <u>3</u> Year <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>59</u> , to <u>3/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/3</u> , 19 <u>59</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Flanks</u>		DATE SIGNED <u>3/6/59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. FLANKS</u>		ADDRESS (Street, city or town, state) <u>104 Locust Cambridge, Md.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 6, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cambridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24a. REC'D BY REGISTRAR <u>MAR 9 '59</u>	
ADDRESS <u>Cambridge Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

CERTIFICATE OF DEATH

1908

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1908	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		TIME OF EXAMINATION [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
CERTIFICATE OF DEATH [Faint text]		[Faint text]	

I hereby certify that the above is a true and correct copy of the original record as the same appears in the files of the Department of Health, Baltimore, Maryland.
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 1908

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3069
CERTIFICATE OF DEATH

03062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>39 Schoolhouse Lane</u>		d. STREET ADDRESS <u>Pine Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Kane</u> Last <u>Darby</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arron Kane</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Annetta Payne, Cambridge, Md.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency - Chronic</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophic Cirrhosis of liver</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 months</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 26, 1953</u> , to <u>March 9, 1959</u> , that I last saw the deceased alive on <u>March 8, 1959</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Hilton A. Wilson</u> M.D. <u>232 Cedar St. Cambridge, Md.</u>		DATE SIGNED <u>March 10, 1959</u>
PHYSICIAN'S NAME (Type) _____		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Sullivan</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Cecil L. Knoch</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03063

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital			d. STREET ADDRESS 301 West End Ave.		
3. NAME OF DECEASED (Type or print) First James Middle D'Ern Last D'Ern			4. DATE OF DEATH Month March Day 19 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1906		9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agriculturist, U. of Md.		10b. KIND OF BUSINESS OR INDUSTRY Ext. Serv		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME John W. D'Ern		
14. MOTHER'S MAIDEN NAME Clara Keyton			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, World War # 2		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Ethel E. D'Ern, 301 West End Ave., Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					INTERVAL BETWEEN ONSET AND DEATH 20 mins.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --- 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work While <input type="checkbox"/> while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3-20-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 22, 1959	22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Howard			ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume
24a. REC'D BY REGISTRAR DATE MAR 23 '59					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03064

3071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		d. STREET ADDRESS <u>205 Church St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 Church St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nancy Lee</u> First <u>Simmons</u> Middle <u>Dillon</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>XX F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1924</u>		9. AGE (In years last birthday) <u>35</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Arron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>218-14-2446</u>		17. INFORMANT Address <u>E.G. Dillon, 233 W. Lanvale St., Balto. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Splanchnica</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-6</u> , 19 <u>59</u> to <u>3-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>59</u> , and that death occurred at <u>3:25</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge</u> DATE SIGNED <u>3-25-59</u>							
ACTUAL SIGNATURE <u>G. W. Barman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Cambridge</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3071

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DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3084

CERTIFICATE OF DEATH

03065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>9 mo</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethlehem</i> <i>05 X-2</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GEORGE WILLARD DRAKE</i> First Middle Last		4. DATE OF DEATH <i>March 12</i> 19 <i>59</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-24-76</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elevator Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Drake</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Elizabeth Wittaker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i> <i>no</i>		16. SOCIAL SECURITY NO. <i>222-8347</i>	
17. INFORMANT <i>Hospital Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Cardiovascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-27</i> , 19 <i>58</i> , to <i>3-1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-28</i> , 19 <i>59</i> , and that death occurred at <i>5:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. De Filippis</i> M.D.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>E. DE FILIPPIS</i>		<i>Cambridge, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Breton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey Williamson</i> ADDRESS <i>Federalburg Md.</i>		24a. REC'D BY REGISTRAR <i>MAR 4 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

DEPARTMENT OF HEALTH

1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3085
CERTIFICATE OF DEATH

03066

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last DREER		4. DATE OF DEATH Month March Day 20 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/72
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicolas Dreer		14. MOTHER'S MAIDEN NAME Margaret VanSant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 9 , 19 56 , to Mar 20 , 19 59 , that I last saw the deceased alive on Mar 19 , 19 59 , and that death occurred at 8:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eastern Shore State Hospital, Cambridge, Md. DATE SIGNED 3-20-59			
ACTUAL SIGNATURE Thomas J. Dreder M.D.		PHYSICIAN'S NAME (Type) Thomas J. Dreder	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/22/59	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar S Lane		24a. REC'D BY REGISTRAR DATE MAR 24 '59	
ADDRESS Church Hill		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

DECEASED
NAME

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

Signature of Registrar

Signature of Medical Officer

Signature of Coroner

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

3072

Item 9 Film G241 4-20-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 210 Race Street		d. STREET ADDRESS 210 Race Street	
3. NAME OF DECEASED (Type or print) Howard First James Middle Hansen, Jr. Last		4. DATE OF DEATH Month March Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1895 (In years last birthday) Approx. 1/60/65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER HELPER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBER	
11. BIRTHPLACE (State or foreign country) UNKNOWN Merchantville, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN Peter Hansen		14. MOTHER'S MAIDEN NAME UNKNOWN Jennie Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. UNKNOWN 163-09-6158	
17. INFORMANT LUCY WILLEY		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 3/12/59	
22a. BURIAL, CREMATION, BURNING (Specify) BURNED	22b. DATE THEREOF MARCH 13, 1959	22c. NAME OF CEMETERY OR CREMATORY GREENLAWN	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		24a. REC'D BY REGISTRAR MAR 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

ALL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 3 may be retained for files. If Health, or in any event within 72 hours after death.

STATE HEALTH DEPT.



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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3073

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JOHN DOE		45		M		W		C		M		H		C		C		C		C		C		C		C		C	
BORN		1910		M		W		C		M		H		C		C		C		C		C		C		C		C	
MARRIED		1935		M		W		C		M		H		C		C		C		C		C		C		C		C	
EDUCATION		H		M		W		C		M		H		C		C		C		C		C		C		C		C	
OCCUPATION		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
RESIDENCE		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
DATE OF DEATH		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
PLACE OF DEATH		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
CAUSE OF DEATH		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
MANNER OF DEATH		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
SIGNATURE OF EXAMINER		C		M		W		C		M		H		C		C		C		C		C		C		C		C	
DATE		C		M		W		C		M		H		C		C		C		C		C		C		C		C	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03068

3086

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL) RURAL CAMBRIDGE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TAYLORS ISLAND		d. STREET ADDRESS TAYLORS ISLAND	
3. NAME OF DECEASED (Type or print) Mary H IGGINS HARRINGTON		4. DATE OF DEATH Month MARCH Day 21 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 25, 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA.	
13. FATHER'S NAME THOMAS W. SIMMONS		14. MOTHER'S MAIDEN NAME LAURA FLETCHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS L KINNAMAN ALEXANDRIA		Address VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURNS ENTIRE BODY 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			INTERVAL BETWEEN ONSET AND DEATH INSTANT
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in fire which destroyed the home.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/21/59 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Taylors Isle. Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MARCH 23, 1959	22c. NAME OF CEMETERY OR CREMATORY CHRIST CEMETERY	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERAL SERVICE		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
ADDRESS CAMBRIDGE MARYLAND.		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

308

FOR STATE
HEALTH DEPT.

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Registrar	
16. Signature of Health Officer		17. Signature of School Health Officer		18. Signature of Public Health Officer	
19. Signature of Sanitary Officer		20. Signature of Health Officer		21. Signature of Health Officer	
22. Signature of Health Officer		23. Signature of Health Officer		24. Signature of Health Officer	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
M
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3087
CERTIFICATE OF DEATH

03069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>		23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>DUFFY</u> Last <u>HUDSON</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSHUA DUFFY</u>		14. MOTHER'S MAIDEN NAME <u>MARY HANCOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>EASTERN SHORE STATE HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u> <u>YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-10</u> , 19 <u>58</u> , to <u>3-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-24-</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Currie</u>		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE E. CURRIER</u>		DATE SIGNED <u>3/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Currie</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
ADDRESS <u>Snow Hill, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

3087

CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM

WOMEN

AND BIRTH RECORDS

DEATH RECORD

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03070

3073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH DORCHESTER COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	c. LENGTH OF STAY IN 1b LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 RACE STREET		d. STREET ADDRESS 115 RACE STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle B. Last INSLEY		4. DATE OF DEATH Month MARCH Day 12, Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME DENWOOD INSLEY	
14. MOTHER'S MAIDEN NAME MARY REDMOND		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 218 34 9363		17. INFORMANT MRS H. B. INSLEY CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/9, 1919 to 3/12, 1919, that I last saw the deceased alive on 3/12, 1919, and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md	
DATE SIGNED 3/13/19		PHYSICIAN'S NAME (Type) Lawrence Maryanov	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MARCH 15, 1959	22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	24a. REC'D BY REGISTRAR DATE MAR 16 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03071

3074

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Pattison Last Kirwan				4. DATE OF DEATH Month March Day 29 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Mover & Farmer				10b. KIND OF BUSINESS OR INDUSTRY Crapo, Md.		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thomas H. Kirwan				14. MOTHER'S MAIDEN NAME Laura Jane Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-20-5687		17. INFORMANT Mrs. Hattie R. Kirwan, 203 Bayly Ave., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 90 MIN. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/13, 1947 , to 27 MAR 1959 , that I last saw the deceased alive on 29 MAR. 1959 , and that death occurred at 6:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter E. Gunby Jr. M.D.				ADDRESS (Street, city or town, state) 105 Church St. Cambridge, Md.			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR.				DATE SIGNED 30 MAR 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	
22d. LOCATION (City, town, or county) Cambridge, Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8, Film G241. 4/14/59 fcy
CERTIFICATE OF DEATH

03072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural * Church Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eliza Middle Meekins Last Matney		4. DATE OF DEATH Month March Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1879??
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Dorchester County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ennalls		14. MOTHER'S MAIDEN NAME Louisa Meekins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-16-3316	
17. INFORMANT William Matney, Church Creek, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse - Primary 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Generalized Arteriosclerosis ② Paralytic Ileus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 18, 1959 , to March 25, 1959 , that I last saw the deceased alive on March 24th, 1959 , and that death occurred on 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 3-31-59 ACTUAL SIGNATURE Hilton H. Wilson, M.D. PHYSICIAN'S NAME (Type) HILTON H. WILSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/1959	
22c. NAME OF CEMETERY OR CREMATORY Meekins Neck		22d. LOCATION (City, town, or county) (State) Meekins Neck, Dor. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Wilson Jr. ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE APR 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

3088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) CAMBRIDGE c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) CAMBRIDGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TAYLORS ISLAND		d. STREET ADDRESS TAYLORS ISLAND e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY FRANCES First HARRINGTON Middle MATTHEWS Last		4. DATE OF DEATH MARCH 21 19 59 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 10, 1916
9. AGE (in years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY STATIONERY STORE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BYRON HARRINGTON	
14. MOTHER'S MAIDEN NAME MARY H SIMMONS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 218 07 0965		17. INFORMANT MRS L KINNAMAN ALEXANDRIA VA. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURNS ENTIRE BODY 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH INSTANT
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died in fire which destroyed the home.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/21/59 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Taylors Isle. Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 3/23/59	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF MARCH 23, 1959	22c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	24a. REC'D BY REGISTRAR MAR 26 59 DATE
VS. A15ME 5M 2/57		24b. REGISTRAR'S SIGNATURE <i>Clash</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Unknown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN: 1b <u>From 2/2/59</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore St. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALEXANDER</u> Middle <u>HAROLD</u> Last <u>MC LEOD</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Date and month unknown, 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>200-18-3281</u>	
17. INFORMANT Address <u>Eastern Shore State Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-vascular Disease</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several yrs</u> <u>" "</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 21, 1959</u> to <u>March 19, 1959</u> , that I last saw the deceased alive on <u>March 19, 1959</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u> DATE SIGNED <u>3/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Simon Virkutis, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Federalburg - rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Wilborn Federalburg, Md</u>		24a. REC'D BY REGISTRAR <u>MAR 26 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3090
CERTIFICATE OF DEATH

03076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE c. LENGTH OF STAY IN 1b 9³/₄ YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POLOMOKE CITY d. STREET ADDRESS 715-WALNUT ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LELIA R. NOTTINGHAM		4. DATE OF DEATH Month Day Year MARCH 14 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 16 1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN		10b. KIND OF BUSINESS OR INDUSTRY SELLING	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL J. SCHOOLFIELD	
14. MOTHER'S MAIDEN NAME IRENE RAY DORSEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 1919 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c) BASAL CELL EPITHELIOMA		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 9 YRS. OVER 1 MONTH.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INVOLUTIONAL PSYCHOTIC REACTION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR. 25 , 19 57 , to MARCH 14 , 19 59 that I last saw the deceased alive on MARCH 13 , 19 59 , and that death occurred at 8:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) CAMBRIDGE, MD. DATE SIGNED MARCH 14, 1959.			
ACTUAL SIGNATURE Harry J. Crawford		M.D. CAMBRIDGE, MD.	
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 16, 1959	
22c. NAME OF CEMETERY OR INTERMENTARY SALEM METHODIST		22d. LOCATION (City, town, or county) (State) POLOMOKE CITY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson		ADDRESS POLOMOKE CITY, MD.	
24a. REC'D BY REGISTRAR MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03077

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	c. LENGTH OF STAY IN lb <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>		e. STREET ADDRESS <u>Near Reid's Grove</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nona</u> Middle <u>Virgie</u> Last <u>Rideout</u>	4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Zakariah Dennis</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Parker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-07-3832</u>		17. INFORMANT Address <u>Mrs. Helen White, Rhodesdale, Md., R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		DATE SIGNED <u>3/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 12, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reid's Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Rhodesdale, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalburg, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03078

CERTIFICATE OF DEATH

Reg. Dist. No.

3077

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND c. CITY OR TOWN DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION STONE BOUNDARY RD.		d. STREET ADDRESS STONE BOUNDARY	
3. NAME OF DECEASED (Type or print) RICHARD First J. Middle ROBBINS Last		4. DATE OF DEATH MARCH Month 19, Day 19 Year 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PLANNER ROBBINS		14. MOTHER'S MAIDEN NAME ANNA ROBBINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218 36 2348	
17. INFORMANT CALVIN ROBBINS Address CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 53 , to 3-19-59 , 19 59 , that I last saw the deceased alive on 3-18-59 , 19 59 , and that death occurred at 3-20-59 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 3-20-59 ACTUAL SIGNATURE Albert E. Bunker M.D. PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D. Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY GREENLAWN		22d. LOCATION (City, town, or county) (State) LECOMPT-FUNERAL CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERAL SERVICE ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR MAR 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hana			

CERTIFICATE OF DEATH

WILLIAM EDWARD
COLLIER

NAME OF DECEASED		WILLIAM EDWARD COLLIER	
AGE		38	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		JANUARY 15, 1922	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEXT OF KIN		[Signature]	
SIGNATURE OF BURIAL OFFICER		[Signature]	
SIGNATURE OF MINISTER OF THE GOSPEL		[Signature]	
SIGNATURE OF CLERGYMAN		[Signature]	
SIGNATURE OF CHURCH OFFICER		[Signature]	
SIGNATURE OF FUNERAL HOME		[Signature]	
SIGNATURE OF CEMETERY		[Signature]	
SIGNATURE OF BURIAL		[Signature]	
SIGNATURE OF INTERMENT		[Signature]	
SIGNATURE OF CREMATION		[Signature]	
SIGNATURE OF OTHER		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3091
CERTIFICATE OF DEATH

03079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Few days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #1</u>				d. STREET ADDRESS <u>/</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Wesley</u> Last <u>Sampson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Sampson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Pinkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Lula Sampson, Hurlock, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>March 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 9</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>3-10-59</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh M. Bellamy</u> ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3092 CERTIFICATE OF DEATH

03080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 0721-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTHA Middle ELIAN Last SCARBOROUGH				4. DATE OF DEATH Month March Day 3 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/73		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Wicks				14. MOTHER'S MAIDEN NAME Hannah Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Eastern Shore State Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19, 1954 , to March 3, 1959 , that I last saw the deceased alive on March 3, 1959 , and that death occurred at 3:23 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas J. Dredge M.D. E. S. S. Hospital, Cambridge, Md. 3-3-59 PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Cecil Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR MAR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

CERTIFICATE OF DEATH

1092

<p>NAME OF DECEASED JAMES H. HARRIS</p>		<p>AGE 64</p>		<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH April 10, 1944</p>		<p>TIME OF DEATH 11:00 AM</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>IMMEDIATE CAUSE Coronary Thrombosis</p>		<p>UNDERLYING CAUSE Atherosclerosis</p>		<p>OTHER CAUSES None</p>	
<p>DATE OF BIRTH April 10, 1880</p>		<p>PLACE OF BIRTH Maryland</p>		<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	
<p>DATE OF DEATH April 10, 1944</p>		<p>TIME OF DEATH 11:00 AM</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Myocardial Infarction</p>		<p>IMMEDIATE CAUSE Coronary Thrombosis</p>		<p>UNDERLYING CAUSE Atherosclerosis</p>		<p>OTHER CAUSES None</p>	
<p>DATE OF BIRTH April 10, 1880</p>		<p>PLACE OF BIRTH Maryland</p>		<p>EDUCATION High School</p>		<p>OCCUPATION None</p>	

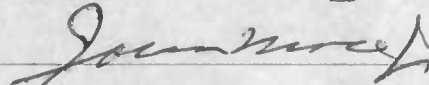
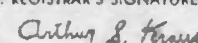
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03081

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLS POINT		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R F D CAMBRIDGE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R F D CAMBRIDGE				d. STREET ADDRESS HIL.S POINT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD		First C. Middle SEWARD Last		4. DATE OF DEATH Month MARCH Day 17 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 3, 1881	
				9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME LEVIN J. SEWARD				14. MOTHER'S MAIDEN NAME MARTHA J. MARSHALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS STEELE WHEATLEY CAMBRIDGE MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion 1120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAECH20)1959		22c. NAME OF CEMETERY OR CREMATORY SPEDDENS SEWARD		22d. LOCATION (City, town, or county) (State) DORCHESTER COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNDAL SERVICE				ADDRESS CAMBRIDGE		24a. REC'D BY REGISTRAR MD. MAR 23 '59	
				24b. REGISTRAR'S SIGNATURE 			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3094

CERTIFICATE OF DEATH

Reg. Dist. No.

03083

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>GERTRUDE</i> Middle <i>TULL</i> Last <i>TULL</i>		4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31, 1901</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>7</i> Hours <i>30</i> Min.	11. IF UNDER 24 HRS. Months <i>5</i> Days <i>7</i> Hours <i>30</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. C.</i>	
13. FATHER'S NAME <i>Fred S. Tull</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Hospital records</i>		Address <i>Hospital records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>491X Bronchopneumonia</i> DUE TO (b) <i>10 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <i>10 days</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mental Deficiency</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1, 1957</i> to <i>Mar. 14, 1959</i> , that I last saw the deceased alive on <i>Mar. 14, 1959</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ettore De Filippis</i> M.D.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp. Cambridge, Md.</i>	
PHYSICIAN'S NAME (Type) <i>ETTORE DE FILIPPIS</i>		DATE SIGNED <i>Mar 19 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MARION STATION, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bradshaw & Sons</i>		ADDRESS <i>Crisfield, Maryland</i>	
24a. REC'D BY REGISTRAR <i>Mar 19 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1002

1002

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1910-01-01		1955-03-15		New York City		Heart Disease		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Place of Burial		Time of Death		Manner of Death		Medical History		Social History		Family History	
Teacher		High School		Married		Catholic		Catholic Cemetery		10:00 AM		Natural		Hypertension, Diabetes		Smoker, Alcohol		None	
Date of Report		Reported By		Signature of Informant		Relationship		Address		City		State		Zip		County		District	
1955-03-16		John Smith		[Signature]		Son		123 Main St		New York		NY		10001		New York		District 1	

3078

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Farrow Waters</u>				4. DATE OF DEATH Month Day Year <u>March 30, 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1881</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Farrow</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Samuel Waters, Jr., Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February</u> , 19 <u>59</u> , to <u>March 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md -4-1-59</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert H. H. H.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03085

3079

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	c. LENGTH OF STAY IN 1b YEAR S	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLASGOW NURSING HOME		d. STREET ADDRESS 325 WILLIS ST.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ORVILLE J. WEBSTER		4. DATE OF DEATH Month Day Year MARCH 23 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 1 1902
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months Days Hours Min. 19 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY LIFE INSURANCE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN WEBSTER		14. MOTHER'S MAIDEN NAME LENA EWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 07 7194	17. INFORMANT Address MRS N ORMAN SMITH CAMBRIDGE MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c) 10 YEARS			INTERVAL BETWEEN ONSET AND DEATH 17 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 27 NOV. 1950 to 23 MAR. 1959 that I last saw the deceased alive on 23 MAR. 1959 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter E. Gunby Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 105 CHURCH ST. 3/24/59	
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR.		CAMBRIDGE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MARCH 26, 1959	22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN. PARK	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNDAL SERVICE		ADDRESS CAMBRIDGE MARYLAND.	24a. REC'D BY REGISTRAR MAR 30 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Home	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03086

3080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN life LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RACE STREET			d. STREET ADDRESS 1 225 GOLDSBOUHH AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First J HARRY Middle WILLEY Last WILLEY			4. DATE OF DEATH Month MARCH Day 27 Year 19 59		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 28, 1891	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFER		10b. KIND OF BUSINESS OR INDUSTRY DORCHESTER CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JAMES WILLEY			14. MOTHER'S MAIDEN NAME EMMA LECOMPTÉ		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MRS D STEVENS CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH INSTANT					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dr. John Mace Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. John Mace Jr.			DATE SIGNED 3/28/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 29, 1959		22c. NAME OF CEMETERY OR CREMATORY GREENLAWN	
22d. LOCATION (City, town, or county) CAMBRIDGE		(State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTÉ FUNERAL SERVICE			ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE MAR 31 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Evans					

3081

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Washington St		d. STREET ADDRESS 104 Washington St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kyna Middle Wingate Last Wingate		4. DATE OF DEATH Month March Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1959
9. AGE (In years last birthday) yrs. 6 Months 6 Days 6 Hours 6 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Wingate		14. MOTHER'S MAIDEN NAME Christine Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Christine Wingate, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from birth to 3/30 , 19 59 , that I last saw the deceased alive on 3/30 , 19 59 , and that death occurred at 10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust Cambridge Md. DATE SIGNED 4/4/59			
ACTUAL SIGNATURE H. H. Hanks M.D.		PHYSICIAN'S NAME (Type) H. H. Hanks	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Hanks		24a. REC'D BY REGISTRAR APR 7 '59	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Robert M. Hanks	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

